KENTUCKY BOARD OF **02/13/02**
SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY
P. O. BOX 1360
FRANKFORT, KENTUCKY 40602
http://www.state.ky.us/agencies/finance/occupations

APPLICATION FOR INTERIM LICENSE

(Please Check Appropriate Block)
[ ] Speech-Language Pathology
[ ] Audiology

(Please Print or Type)
1. Name: _____ S. S. No. _____

2. Name as it appears on transcript: _____

3. Address: _____
Street City State Zip
4. Telephone: Home ( ) _____ Work ( ) _____

5. U.S. Citizen: [ ] Yes [ ] No If no, have you declared your intention to become a citizen? [ ] Yes [ ] No

6. Date of Birth: _____

7. Have you ever applied for licensure in Speech-Language Pathology or Audiology in Kentucky? [ ] Yes [ ] No
If yes, give license number and/or reason for denial: _____

8. Have you ever been convicted of a felony? [ ] Yes [ ] No If yes, explain: _____
_____

9. Education:

School	Names and Locations	Dates Attended		Date of Graduation		Number of Hours or Credits	Degrees Obtained
		From	To	Month	Year		
UNDER - GRADUATE SCHOOL							
GRADUATE SCHOOL							

AFFIDAVIT

I do hereby swear or affirm that the above statements made by me in this application are true, complete and correct to the best of my knowledge.

APPLICANT SIGNATURE _____ DATE _____

A nonrefundable application fee of $50 (fifty dollars) for interim licensure must be attached to this form ($100 if dual licensure). Please make check or money order payable to the Kentucky State Treasurer. DO NOT SEND CASH. Please mail the completed application and the application fee to the address above.

DO NOT WRITE BELOW THIS LINE – FOR BOARD USE ONLY

FEE RECEIPTED
Amount $ _____ Date: _____

Lic. No. _____ Date: _____

BOARD REVIEW DATE: _____
[ ] Approved **[ ]** Denied
Members: _____
_____

PLAN OF ACTIVITIES FOR
POSTGRADUATE PROFESSIONAL EXPERIENCE

This portion of the application must be completed by the supervisor

I. **PPE Setting**

A. Facility Name: _____

B. Address: _____
Street City State Zip

C. Telephone Number: Home ( ) _____ Work ( ) _____

D. Beginning Date of PPE: _____/_____/_____ Estimated Ending Date: _____/_____/_____
[ ] Full-Time (9 months) [ ] Part-Time: _____ hrs/week _____ # weeks

Hours worked per week:	Required length of employment:
25-29 hours/week	12 months (48 weeks)
20-24 hours/week	15 months (60 weeks)
15-19 hours/week	18 months (72 weeks)

II. **Supervisor**

A. Name: _____ KY License Number: _____

B. Address: _____
Street City State Zip

C. Telephone Number: Home ( ) _____ Work ( ) _____

D. Place/Address of Employment: _____
_____

III. **Plan of Professional Activities**

A. Applicant Activity:

Applicant Activity	Number of HOURS Each WEEK to be Spent by Applicant
1. Assessment , diagnosis and or evaluation	
2. Screening	
3. Habilitation/Rehabilitation	
4. Inservice Training	
5. Record Keeping	
6. Other (specify)	
TOTAL (equal to hours/week)	

B. Supervisory Activity:

Supervisory Activity	On-Site Observations (minimum of 6 hours per segment)	Other monitoring Activities (minimum of 6 hours per segment)
Segment One		
Segment Two		
Segment Three		
Total On-Site Occasions*		
Total Other Activities*		

*must be minimum of 18 total in each area

AFFIDAVIT

I, the named supervisor for the above named applicant for interim licensure, have devised and discussed this plan of activities for post graduate professional experience with said applicant and accept responsibility for its implementation. Further, I do hereby certify that my Kentucky License is current, and will be maintained throughout this period.

SIGNATURE OF SUPERVISOR _____ DATE _____